Tang EY, Birdi R, Robinson L.

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***International Psychogeriatrics* 2016**

DOI: http://dx.doi.org/10.1017/S1041610216001204

International Psychogeriatrics (2016), 00:0, 1–6 © International Psychogeriatric Association 2016
doi:10.1017/S1041610216001204

BRIEF REPORT

Attitudes to diagnosis and management in dementia care: views of future general practitioners

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ABSTRACT

Considerable international governmental support is focused on the timely diagnosis of dementia and post-diagnostic care of people with dementia. Identifying those at high risk of dementia is one approach to timely diagnosis. General practitioners (GPs) are well-placed clinicians in the community to provide both pre- and post-diagnostic dementia care. However, GPs have in the past consistently demonstrated low confidence in both diagnosing dementia and providing care for these complex patients particularly for patients in the post-diagnostic phase. It is currently unclear how future GPs view dementia care. We aimed to evaluate the current attitudes and experiences of future GPs in dementia care and their views on targeting high risk groups. All (n = 513) GP trainees were approached by email to participate in a cross-sectional web and paper-based survey in the North of England. A further reminder was sent out two months after the initial invitation. We received 153 responses (29.8% response rate, 66.7% female, average age 31 (range 25–55 years old). The main difficulties encountered included coordinating supporting services for carers and the person with dementia and responding to co-existing behavioral and psychiatric symptoms. Further education in dementia management was considered to be important by respondents. GP trainees were generally very positive about their future role in caring for people with dementia, particularly in the area of earlier diagnosis via identification of high-risk individuals. Future GPs in one area of England are very positive about their key role in dementia care. In order to facilitate the delivery of high quality, community-based care, work is required to establish core post-diagnostic dementia support services. Further research is needed to identify effective systems to enable accurate assessment and to ensure earlier diagnosis in high-risk groups.

Key words: dementia, primary care, education, behavioral and psychological symptoms of dementia, community care

Introduction

Dementia remains a cause of significant disability and presents multiple challenges for primary care. Increasing prevalence associated with population aging has driven government responses internationally. In England, dementia is a national policy priority with the Prime Minister's Dementia Challenge placing General Practitioners (GPs) at the center of post-diagnostic care and increasing emphasis on prevention while searching for a cure (Department of Health, 2015). With low evidence to support population screening, modifiable risk factor reduction has been seen as the most effective way to potentially reduce and delay the onset of new dementia cases (Norton *et al.*, 2014). Risk scores to predict an individual's future susceptibility to developing dementia, utilizing a combination of these risk factors, could also be used to guide clinical management (Tang *et al.*, 2015). Early identification and intervention of dementia symptoms has the potential to improve outcomes for the person with dementia (PwD) and their families (Banerjee *et al.*, 2007). GPs are well positioned to notice the possible cognitive decline of individuals because of the continuity of care and existing inter-personal relationships. However, GPs are often anxious about labeling patients as "early/pre-dementia" (Cahill *et al.*, 2006) despite the fact that most patients and families would want to know as it empowers the individual to participate in the planning of their care (Carpenter *et al.*, 2008). There is also wide variation in primary care physicians' abilities and confidence in diagnosing and managing dementia (Iliffe *et al.*, 2009). The aim of this study was to explore the current views

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and attitudes of future GPs toward dementia care and management.

Methods

All GP trainees based in the North of England were approached to participate in the study (July to October 2014). The survey was formatted and delivered in both electronic and paper formats. It was based on a previous survey carried out on GPs nationally (Ahmad *et al.*, 2010) and derived from an earlier trial (Turner *et al.*, 2004) but amended for GP trainees by including questions on demographics, attitudes to dementia training, and risk assessment. This questionnaire was piloted to academic GP trainees (Tang and Robinson, 2014). Trainees were invited to participate via email; a reminder email was sent out two months later. Other routes of publicity included face-to-face encouragement at teaching sessions. A financial prize was offered to two randomly selected participants. Analysis was performed using Microsoft Excel 2013.

Results

There were 153 respondents from a total of 513 (response rate 29.8%, 66.7% female) with all areas and years of training represented. The average age of the respondent was 31 years old (range 25–55 years). Less than a third (27.5% n = 42) reported that they would have some form of training in dementia diagnosis and management during their trainee years compared to 57.5% (n = 88 trainees) who reported that they would not receive any training.

Management of dementia

Trainees who had completed at least six months of primary care (69% of trainees, n = 105) were asked to evaluate their experience and attitudes to specific aspects of dementia management (Table 1).

The main difficulties encountered by trainees included coordinating supporting services for carers (66.7%, n = 70) and PwD (61.9%, n = 65) and responding to co-existing behavior (64.8%, n = 68) and psychiatric symptoms (61.9%, n = 65). Fewer trainees found issues such as discussing the probable diagnosis with the PwD (44.8%, n = 47) and their families (38.1%, n = 40) as being a difficult issue.

Attitudes to dementia care

Over 90% (n = 123) of trainees agreed that primary care has a key role to play in identifying those at high risk of dementia with a further 78% of trainees (n = 109) feeling that those at high risk (e.g. post-stroke) should be closely monitored for cognitive impairment (Table 2). Around two-thirds of trainees felt that a risk prediction tool may be useful. Over 90% of trainees (n = 127) disagreed that GPs have a limited role in the ongoing management of dementia with over 85% of trainees (n = 121) feeling that much can be done to improve the lives of PwD. Referral to services for families' was also felt to be important with 73% (n = 101) of trainees disagreeing with the statement that "there is little point in referring families to services as they do not want to use them." Trainees were less decisive when it came to who should be diagnosing dementia as although 55.1% (n = 76) of trainees agreed that specialist services should diagnose dementia around one in five trainees disagreed or strongly disagreed with the same statement. Similarly although just under half of trainees disagreed that managing dementia was more frustrating than rewarding, one in five trainees again felt that this statement was true.

Barriers to care

The main barriers to care (Figure 1) included lack of time and familiarity with advances in dementia management and community services available. Despite these barriers, over two-thirds of trainees felt that by the end of training they would be confident in diagnosing dementia (70%) and managing it in the community (68.1%) with 77% feeling confident providing information on dementia to PwD and their carers.

Dementia training

Around 80% of trainees agreed or strongly agreed with further training in dementia management during their years in GP training (83.1%) and also following completion of training in the form of a dedicated educational program in dementia (79.7%).

Discussion

This survey of future GPs in one area of England has revealed a very positive approach to dementia care, with 85% of respondents feeling that "much can be done to improve the lives of PwD."

Dementia management

Trainees were generally positive about dementia management in the community. In the absence of a cure for dementia, PwD and their families rely on their GP for information to help manage the condition in the community. The lack of time and difficulties in coordinating care in the

Table 1. Management of dementia (n = 105)

	NUMBER OF TRAINEES (%)						
	NOT AT ALL DIFFICULT	SLIGHTLY DIFFICULT	SOMEWHAT DIFFICULT	DIFFICULT	VERY DIFFICULT	EXTREMELY DIFFICULT	DON'T KNOW
Reaching a probable diagnosis yourself	1 (1.0)	36 (34.3)	30 (28.6)	23 (21.9)	13 (12.4)	2 (1.9)	0 (0)
Discussing the probable diagnosis with the patient	1 (1.0)	23 (21.9)	32 (30.5)	26 (24.8)	17 (16.2)	4 (3.8)	2 (1.9)
Discussing the probable diagnosis with the family	1 (1.0)	30 (28.6)	32 (30.5)	20 (19.1)	16 (15.2)	4 (3.8)	2 (1.9)
Responding to behavior or psychological symptoms	0 (0)	11 (10.5)	32 (30.5)	32 (30.5)	21 (20.0)	8 (7.6)	1 (1.0)
Responding to co-existing behavior 0problems	1 (1.0)	11 (10.5)	23 (21.9)	35 (33.3)	25 (23.8)	8 (7.6)	0 (0)
Responding to any psychiatric symptoms	1 (1.0)	14 (13.3)	24 (22.9)	31 (29.5)	29 (27.6)	5 (4.8)	0 (0)
Getting information about support services for people with dementia	5 (4.8)	19 (18.1)	32 (30.5)	30 (28.6)	12 (11.4)	3 (2.9)	3 (2.9)
Getting information about support services for carers	2 (1.9)	16 (15.2)	29 (27.6)	28 (26.7)	23 (21.9)	5 (4.8)	1 (1.0)
Coordinating support services for people with dementia	2 (1.9)	12 (11.4)	19 (18.1)	33 (31.4)	27 (25.7)	5 (4.8)	4 (3.9)
Coordinating support services for carers	2 (1.9)	8 (7.6)	19 (18.1)	32 (30.5)	31 (29.5)	7 (6.7)	4 (3.9)
Getting specialist advice by telephone	2 (1.9)	19 (18.1)	26 (24.8)	26 (24.8)	15 (14.3)	8 (7.6)	7 (6.7)
Getting information about anti-dementia medication	5 (4.8)	17 (16.2)	35 (33.3)	24 (22.9)	15 (14.3)	5 (4.8)	3 (2.9)

community for PwD and their families' identified by GP trainees is consistent with previous studies (Turner *et al.*, 2004). However, PwD and their families/carers do not receive either sufficient information or receive information in an acceptable format (van der Roest *et al.*, 2009). GPs are key sources of information for PwD and their families. The persistent unfamiliarity with both the available services and how to refer to such services will become a hindrance to post-diagnostic care. However, when GPs are exposed to dementia-specific training, GPs were generally more positive about post-diagnostic services compared to those that had not gone through any formal training (Moore and Cahill, 2013). Behavioral disorders have consistently been found to be a perceived difficulty when managing PwD in the community. These areas may be well targeted by educational programs, which surveyed future GPs are keen for.

Risk assessment in dementia

There has been an international push toward early detection of dementia (Borson *et al.*, 2013). Future GPs surveyed in this study are keen to identify these high-risk individuals to ensure timely diagnosis. It has been suggested that early detection and management of dementia could be improved through GP training and education (Koch and Iliffe, 2010). The majority of the trainees in this survey have acknowledged this. Furthermore, around two-thirds of trainees felt that a risk assessment tool may prove to be useful in this area. GPs are familiar with risk assessment tools, such as the ones that have been used in cardiovascular disease (e.g. QRISK2 (Siontis *et al.*, 2012)). Similar tools could be used to help risk assess an individual for dementia. Dementia is a complex disease caused by a combination of genetic and environmental risk factors. However, although many risk factors for the occurrence and progression of dementia have been identified, their utility for identifying dementia risk through prediction models remains unclear (Tang *et al.*, 2015). No model has gained widespread acceptance or utilization in clinical or research practice.

Limitations of the study

Although to the authors' knowledge, this is the first survey of GP trainees that has looked at the experience, barriers, and attitudes to dementia

Table 2. Attitudes to dementia care (n = 153)

	NUMBER OF TRAINEES (%)						
	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	DO NOT KNOW	NO RESPONSE
Providing a patient with a diagnosis is usually more helpful than harmful	20 (13.1)	75 (49.0)	22 (14.4)	18 (11.8)	3 (2.0)	1 (0.7)	14 (9.2)
Managing dementia is more often frustrating than rewarding	3 (2.0)	24 (15.7)	44 (28.8)	56 (36.6)	12 (7.8)	0 (0)	14 (9.2)
Much can be done to improve the quality of life for people with dementia	41 (26.8)	80 (52.3)	12 (7.8	5 (3.3)	0 (0)	1 (0.7)	14 (9.2)
Dementia is best diagnosed by specialist services rather than by the primary care team	18 (11.8)	58 (37.9)	32 (20.9)	29 (19.0)	1 (0.7)	0 (0)	15 (9.8)
It is better to talk in euphemistic (non-offending) terms when discussing the condition with someone with dementia	4 (2.6)	8 (5.2)	41 (26.8)	46 (30.1)	22 (14.4)	18 (11.8)	14 (9.2)
Families would rather be told about their relative's dementia as early as possible	25 (16.3)	80 (52.3)	28 (18.3)	1 (0.7)	2 (1.3)	3 (2.0)	14 (9.2)
The primary care team has a very limited role to play in the ongoing care of people with dementia	0 (0)	1 (0.7)	10 (6.5)	66 (43.1)	61 (39.9	1 (0.7)	14 (9.2)
Much can be done to improve the quality of life of carers of people with dementia	39 (25.5)	80 (52.3)	16 (10.5)	4 (2.6	0 (0)	0 (0)	14 (9.2)
Patients with dementia can be a drain on resources with little positive outcome	1 (0.7)	17 (11.1)	29 (19.0	57 (37.3)	34 (22.2)	1 (0.7)	14 (9.2)
There is little point in referring families to services as they do not want to use them	0 (0)	7 (4.6)	25 (16.3)	64 (41.8)	37 (24.2)	6 (3.9)	14 (9.2)
Primary Care has a key role to play in identifying patients at high risk of dementia	49 (32.0)	74 (48.4)	7 (4.6)	5 (3.3)	0 (0)	1 (0.7)	17 (11.1)
Patients at risk of developing dementia such as those who have had a stroke should be closely monitored for cognitive impairment.	26 (17.0)	83 (54.2)	18 (11.8)	8 (5.2)	3 (2.0)	1 (0.7)	14 (9.2)
A risk prediction tool (e.g. QRISK2 score for cardiovascular disease), would be useful to help identify those at high risk of dementia	25 (16.3)	60 (39.2)	35 (22.0)	10 (6.5)	3 (2.0)	6 (3.9)	14 (9.2)

Figure 1.- Colour online, B/W in print

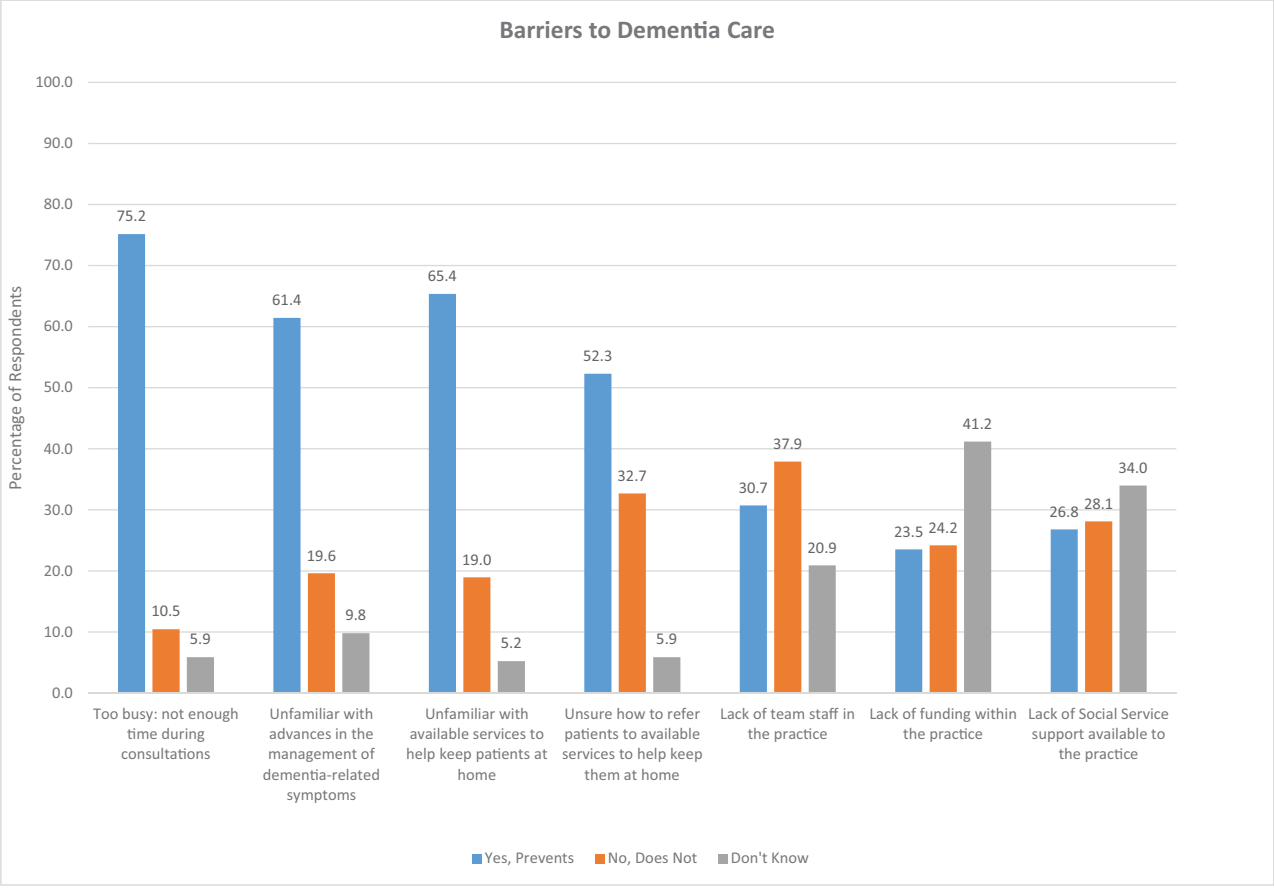

Figure 1. (Colour online) Barriers to dementia care.

care, there are several limitations. The response rate of 30% is low but the age, gender, and years of training are representative of the trainee population in this area. A further limitation of this study is that this was conducted in a single area of England. We have not explored whether other areas may be able to offer more dementia-specific training. Nor have we explored whether other areas have similar levels of perceived barriers e.g. service access or referral pathway familiarity. These limitations may limit the generalizability of these findings. However, when compared to previous surveys of GPs, our findings are comparable.

Conclusions

GPs play an important role in identifying those at the greatest risk of dementia and to manage these individuals and their families post-diagnosis. To ensure that these individuals continue to live well in the community, GPs need to be well supported themselves via access to services, specialist advice, and potentially through educational programs.

Conflict of interest

None.

Description of authors' roles

Eugene Yee Hing Tang formulated the research question, designed, and carried out the study and wrote the paper. Ratika Birdi was responsible for collating and analyzing the data as well as critically reviewing the manuscript. Louise Robinson was responsible for assisting in the formulation and design of the study. She was also responsible for critical review of the manuscript.

Acknowledgments

The authors would like to thank Prof. S. Iliffe and Jane Wilcock for the use of the questionnaire currently being used in the EVIDEM:ED trial, which has been adapted for GP Trainees in this study. Eugene Tang is supported by an NIHR Doctoral Research Fellowship (DRF-2015-08-006); Louise Robinson is supported by NIHR

Professorship (NIHR-RP-011-043). This study was funded by the Royal College of General Practitioners, Scientific Foundation Board Grant (SFB 2014-03). The funders played no role in the in the design, execution, analysis and interpretation of data, or writing of the study

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